STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555652	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Creek Healthcare Center	650 W. Alluvial Clovis, CA 93611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care in accordance with professional standards of practice to prevent pressure ulcers (PU- a localized injury to the skin and underlying tissues) for one of four residents (Resident 1) when licensed nurses assessed Resident 1 upon admission on [DATE] and were aware of the Resident 1's high risk for pressure ulcers and did not implement effective interventions to prevent pressure ulcers such as changes for size, dimension, weekly description. Resident 1 was assessed to have a stage 2 (a partial-thickness skin injury that involves damage to the epidermis (outer layer of skin) and extends into the dermis (middle layer of skin) pressure ulcer on 5/5/25 and nurses did not implement interventions to prevent wound progression.Resident 1 was diagnosed by a wound specialist physician with an unstageable (a type of pressure injury where the depth of the wound cannot be determined because it is covered by slough or eschar. Slough is yellow, gray, or green dead tissue, while eschar is a hard, black or brown crust that covers the wound.) pressure ulcer on 6/9/25 and required wound vacuum (wound vac-medical device that uses suction to promote wound healing) for healing. These failures resulted in an avoidable Stage 2 pressure ulcer to left buttocks and shearing (a type of skin damage that occurs when tissue layers are pulled in opposite directions, causing them to separate) to the right buttocks that progressed to two avoidable Stage 4 (a severe form of pressure injury that involves full-thickness tissue loss, exposing bone, tendon, or muscle) pressure ulcers (left and right buttocks), suffering, pain and loss of mobility. Resident 1 stated because of the pressure ulcers he acquired, he did not feel the facility acted promptly in providing the care he needed to improve, which caused him to limit his rehabilitation because he was concerned about his wounds. Resident 1 made the decision to be discharged home on 8/8/25 with wound care and wound a vac because he was not accepted at another facility due to his wounds. Resident 1 experienced psychosocial harm when he felt hopeless in his recovery and did not feel the facility addressed his psychosocial needs and quality of care. During a review of Resident 1's admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission record indicated, Resident 1 was admitted from the general acute care hospital to the facility on 5/2/25. Resident 1 has a history that includes but not limited to cervical vertebral fracture with surgical intervention(a break in one or more of the seven vertebrae (bones) that make up the neck that required a surgical procedure to repair and stabilize structure), impaired/decrease mobility (a limitation in the independent and purposeful movement of the body or one or more extremities), idiopathic peripheral autonomic neuropathy (damage to the nerves that control automatic bodily functions, such as heart rate, blood pressure, digestion, and bladder function), ankylosing spondylitis (a chronic inflammatory disease that primarily affects the spine), cirrhosis of the liver (disease characterized by the formation of scar tissue (fibrosis) that replaces healthy liver cells), muscle weakness (a decreased ability of muscles to generate force or contract effectively), and neuromuscular dysfunction of the bladder (nerve damage to the brain, spinal cord, or peripheral nerves disrupts the coordination between the nerves and muscles needed to store and empty urine).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive (the process of acquiring knowledge and understanding through thought, experience, and the senses) and physical function) assessment dated [DATE], Resident 1's MDS assessment indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 15 out of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating no cognitive impairment.During an interview and observation on 8/4/25 at 3:45 p.m., with Resident 1, Resident 1 was observed up in his wheelchair with a wound vac attached along the side of the wheelchair, Staff wheeled Resident 1 to a private area at his request for the interview. Resident 1 stated he was not comfortable discussing his care with the facility staff around because he stated he had concerns with the care he received. Resident 1 stated, he came into the facility with hopes of rehabilitating. Resident 1 stated he wanted to go home after he improved with physical therapy but stated that it did not occur in the facility because he was concerned about his wounds which he felt interfered with his physical therapy. Resident 1 stated, the facility delayed treating his wounds to his buttocks which caused him to lose hope for his recovery and interfered with his physical therapy and rehabilitation. Resident 1 stated, he mentally, physically and emotionally has declined since his arrival into the facility. Resident 1